PERFORMANCE AUDIT REPORT

Reviewing the Medicaid Program's Use of Generic Drugs

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
March 2000

00-06

Legislative Post Audit Committee

Legislative Division of Post Audit

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March 17, 2000

To: Members, Legislative Post Audit Committee

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This report contains the findings, conclusions, and recommendations from our completed performance audit, *Reviewing the Medicaid Program's Use of Generic Drugs*.

The report also contains an appendix showing information on the drugs available from more than 1 source that were included in our sample. For each drug, the chart includes the ingredient and brand name, what the drug is frequently used for, the total number of prescriptions for all versions of the drug, the number of prescriptions for the name brand version, and how much was spent on all versions of that drug in fiscal year 1999.

The report includes several recommendations for the Department of Social and Rehabilitation Services. We would be happy to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other State officials.

We would be happy to discuss the findings presented in this report with any legislative committees, individual legislators, or other State officials. These findings are supported by a wealth of data, not all of which could be included in this report because of space considerations. These data may allow us to answer additional questions about the audit findings or to further clarify the issues raised in the report.

Barbara J. Hinton
Legislative Post Auditor

EXECUTIVE SUMMARY
LEGISLATIVE DIVISION OF POST AUDIT

Question 1: How Well Does Kansas Encourage The Use of Generic Drugs?

Question 2: What Other Measures Does the Department Take to Control Medicaid Drug Costs, and What Additional Steps Should It Explore?

The Department has implemented many effective cost-control measures in the Medicaid pharmacy program. *In addition to the pricing restrictions that encourage pharmacies to dispense lower-cost versions of drugs, the Program doesn't pay for certain types of drugs, and it requires proof of medical necessity for expensive drugs and drugs subject to abuse. Reviews help ensure drugs are prescribed appropriately. The Department limits the initial supply of any drug and limits how often it will pay for refills. There are further limitations on specific drugs, such as Viagra. Among the ways the Department controls what the State pays for each prescription are lowering reimbursement for specific drugs, making sure other insurance pays before Medicaid does, having clients make co-payments for prescriptions, and collecting rebates from pharmaceutical manufacturers. (Those collections reached about $25 million in fiscal year 1999.) The Department also takes steps to identify and pursue fraud and abuse.*

To help control drug costs even further, the Department could expand some existing programs and consider implementing initiatives other states are trying. *For example, Kansas might expand its coverage of over-the-counter drugs, expand counseling for patients with chronic conditions, and require proof of medical necessity for more drugs. It might implement additional ideas, such as starter doses and paying pharmacists to split expensive tablets. These ideas likely would result in some cost savings to the Medicaid Program, but the Department should research them further to determine whether they would result in significant savings in Kansas.*

This audit was conducted by Jill Shelley and Robin Kempf. Cindy Lash was the audit manager. If you need any additional information about the audit's findings, please contact Ms. Shelley at the Division's offices. Our address is: Legislative Division of Post Audit, 800 SW Jackson Street, Suite 1200, Topeka, Kansas 66612. You also may call us at (785) 296-3792, or contact us via the Internet at LPA@lpa.state.ks.us.

Reviewing the Medicaid Program's Use of Generic Drugs

The Medicaid Program provides medical benefits for qualified individuals, benefits including prescription drugs. During fiscal year 1999, the Program's cost for prescription drugs was about $141 million. The Department of Social and Rehabilitation Services is the State agency that administers the Medicaid Program in Kansas.

Legislative concerns have been raised about the extent to which the Program makes use of generic equivalents for name brand drugs, and what the program does to encourage the use of generic drugs. Generally, generic equivalents are less costly, and the more such drugs are used, the less the Program's costs for prescription drugs. This performance audit answers the following questions:

1. **How often is the Medicaid Program paying for name brand drugs when generic equivalents are available, and what is the additional costs of using the name brands?**

2. **How do reimbursement rates for drugs in the Kansas Medicaid Program compare with reimbursement rates in other states?**

3. **What incentives could be used to encourage the use of generic drugs?**

To answer these questions, we analyzed data we received from the Medicaid Management Information System for fiscal year 1999. We interviewed representatives of the Department of Social and Rehabilitation Services, the Drug Utilization Review Board, and Blue Cross/Blue Shield, the Department's fiscal agent for the Medicaid Program. We also spoke with Blue Cross/Blue Shield and Department staff about controls they use to ensure integrity of computerized data. We interviewed

members of the Kansas Pharmacists Association and surveyed members of the Kansas Medical Society's Council. In addition, we contacted Medicaid officials in 10 states, as well as representatives of the federal Health Care Financing Administration, the National Conference of State Legislatures, and Advanced Paradigm, the current pharmacy benefits manager for State employees. We also reviewed applicable State and federal laws.

A copy of the scope statement for this audit approved by the Legislative Post Audit Committee is included in Appendix A. For reporting purposes, we've collapsed these three questions into one and placed additional information about cost-saving measures that don't involve generic drugs into a separate question.

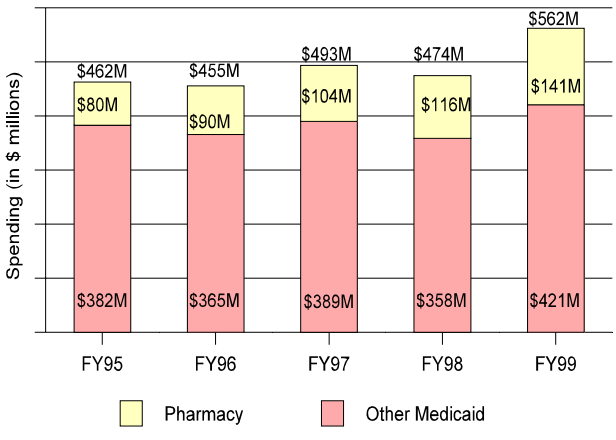
In conducting this audit, we followed all applicable government auditing standards. Our findings begin on page 6, following a brief overview.

Overview of the Kansas Medicaid Prescription Drug Program

The Kansas Medicaid Program provides medical assistance, including prescription coverage, for about 200,000 Kansans who have very limited income and resources. This program, established in Title XIX of the federal Social Security Act, is funded jointly with federal and State moneys. Currently, the federal government pays 60% of the costs of health care and the State pays for the remaining 40%.

Prescription Drug Costs Make Up An Increasing Portion of Total Medicaid Costs

Prescription drug spending has increased steadily from the $80 million spent in fiscal year 1995. By fiscal year 1999, about $140 million of State and federal money was spent on prescription drugs in the Kansas Medicaid Program, 25% of the entire amount spent on Medicaid. (The majority of the increases in spending are for Kansans who are elderly or disabled, as illustrated in the graphic on the next page.) The State recovered nearly $25 million of that from pharmaceutical manufacturers through rebates. Collecting these rebates, which the federal government requires manufacturers to pay, has recovered significant amounts of money for the State. (A profile on rebates appears on page 11.)



Medicaid spending has fluctuated somewhat, but spending for prescription drugs consistently increased.

The issue of rising costs needs to be considered within the context of the cost of health care in general. While this audit focused only on what's happening in the prescription drug program, it's important to realize that drug therapies can cost-effectively prevent hospitalization or other expensive care. For example, the Department's decision to allow Medicaid coverage for smoking cessation drugs was based on studies that show health care costs are higher for smokers.

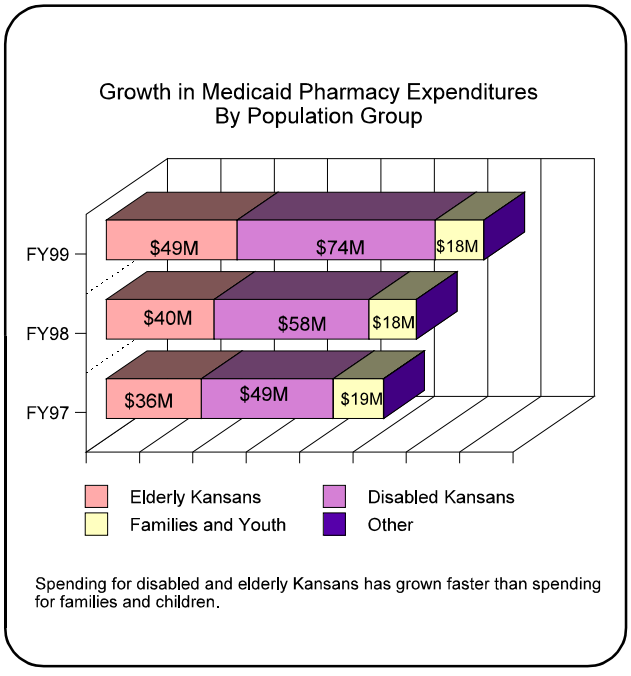
Some Medicaid clients receive their health care through a health maintenance organization that contracts with the Department. The prescription data related to these managed care clients, who make up about 11% of the total Medicaid population, aren't included in this report for two reasons:

- The current HMO that contracts with SRS to provide managed care, FirstGuard Health Plan, until recently has maintained its own prescription benefits and usage information separately from that of the rest of the Medicaid clients.
- In the rest of the Medicaid Program, the State pays for each prescription as it is filled. The State pays for prescriptions under the managed care plan by paying a fee to the HMO for each person in managed care. The fee includes prescription benefits.

The Department of Social and Rehabilitation Services Administers the Medicaid Program In Kansas

The system for determining whether clients should receive drugs and how those drugs are paid for involves the Department of Social and Rehabilitation Services, contractors, and other public and private entities. Here are some of the major players:

- The Department oversees the Kansas Medicaid Program. Department staff responsibilities include determining client eligibility, enrolling providers to serve clients, reporting to federal authorities, directing research and policy issues, verifying claims, ensuring data accuracy, and the like.



Spending for disabled and elderly Kansans has grown faster than spending for families and children.

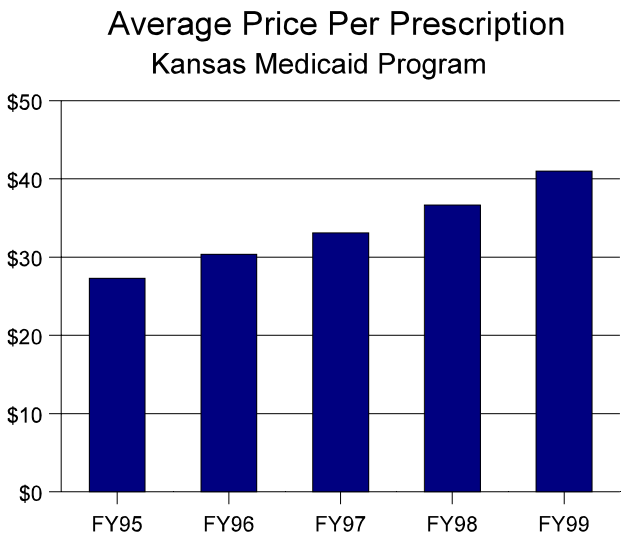
- The Department contracts with Blue Cross/Blue Shield to maintain the computer system that tracks the more than 300,000 claims that come in each month. The computer system holds the current price Medicaid will pay for that drug, information it buys from a subcontractor. That computer system also provides the pharmacy with on-line information that includes whether the client is eligible to receive a medication, whether that drug could interact with another drug the client

is taking, and the like. Blue Cross/Blue Shield sends payments to pharmacies for these claims.

! The Drug Utilization Review Board oversees a program to check on whether drugs are used properly in the Medicaid Program. It also approves drugs for which clients must prove medical necessity, advises the Department on modifications to the Program, and provides educational information to Medicaid health care providers on how to improve their prescribing and dispensing practices. The Board is made up of health care providers, including pharmacists, and works with the Department and with the University of Kansas School of Pharmacy, the current research subcontractor for the State.

Changes in Health Care and Rising Consumer Demand for New, More-Expensive Drugs Have Contributed to the Overall Growth of Prescription Drug Costs

Because of advances in medical research, prescription drugs are used to treat a wider array of illnesses today than ever before. Medicines are used to treat patients with conditions that previously were considered to be untreatable or were treatable only though surgery or other more invasive measures. New medicines can prevent serious illnesses or conditions, such as heart disease or high blood pressure, and other new drugs have fewer side-effects and can increase patients' quality of life. Doctors are turning more frequently to the newer drugs to help their patients.



At the same time, consumer demand for these treatments is growing. Consumers have more access to information about available drugs on the Internet, and they also receive information through the new direct-to-consumer advertising on television and in magazines. Studies have shown a significant increase in the use of several drugs that are the most highly advertised to the public.

Newer drugs are expensive, largely because of the heavy costs associated with researching and developing them and bringing them to market. Even though most new drugs are protected by 20-year patents that give manufacturers the exclusive right to sell the drug, manufacturers usually have only 11 or 12 years left on the patent after they finally receive approval from the U.S. Food and Drug Administration to place the drug on the market. This shorter time to recover costs leads to higher prices, which are reflected in the increase in per-prescription cost for the Kansas Medicaid program.

When asked why Medicaid spending for drugs is increasing faster than the number of beneficiaries, Kansas physicians we surveyed most frequently cited increased use of new more-costly drugs. The next most common answers were the availability of drug therapy for more conditions and the increase in direct-to-consumer advertising.

Question I: How Well Does Kansas Encourage the Use of Generic Drugs?

Nearly 60% of the prescriptions filled for Medicaid clients in fiscal year 1999 were for drugs that had generic versions available. However, these prescriptions accounted for only about 25% of the amount spent on prescription drugs that year.

To help ensure that the lowest-cost version of a drug (usually a generic) is dispensed when several versions of a drug are available, the Department primarily relies on federal reimbursement caps placed on the higher-cost drugs. When we looked at a sample of high-cost and high-use drugs with generic equivalents, we found that Kansas' Medicaid Program paid for the generic versions of those drugs more than 80% of the time. The Department might be able to further increase the use of lower-cost versions of drugs by following other states' practices, but not without changes in laws, regulations, or policies. These and other findings are described in more detail below.

Generic Versions Were Available for Nearly 60% of the Prescriptions Filled for Medicaid Clients in Fiscal Year 1999

The Medicaid Program paid for 3.4 million prescriptions for all kinds of drugs during fiscal year 1999. We found 59% of those prescriptions were for drugs available from more than 1 source. If a drug is available from more than one source, it typically has at least one generic version. (More information about what's meant by "generic" drugs is in a profile on the next page.) The other 41% were prescriptions for drugs available from a single source, most likely because the drug formulas are still protected by a patent.

The following table shows that, even though a majority of the prescriptions were for drugs with multiple sources, these prescriptions only made up a little more than one-fourth of the total spent for prescriptions.

Drugs with . . .	# of prescriptions filled	% of total prescriptions	$ spent on drugs	% of total $
> 1 source	2 million	59%	$28.8 million	24%
only 1 source	1.4 million	41%	$91.8 million	76%

Like Other States, Kansas Primarily Relies on Federal Reimbursement Caps To Help Ensure That Pharmacies Dispense the Lower-Cost Versions of Drugs

Having clients use a less-expensive version of a drug (typically the generic) is one way to cut costs in a prescription program. However, Kansas law doesn't allow the Department to require the use of generic drugs for Medicaid clients, so the Department must focus its efforts on encouraging the use of lower-cost drugs.

Historically, the Department has done this by relying on caps set by the Health Care Financing Administration. Federal law places a cap on reimbursement whenever there are **3 or more equivalent versions** of a particular drug. That cap is 150% of the price of the lowest-cost version of the drug. For example, if a drug is available in version A (perhaps a generic) for 50¢ a tablet, version B for 65¢ a tablet, and version C (say, the name brand) for $1 a tablet, the pharmacy will be reimbursed no more than 75¢ a tablet.

What Is a "Generic Drug"?

"Generic version of a drug" can have various meanings. In this report, we mean drugs that are "bioequivalent," a term used in Kansas law. Kansas law refers to the federal Food and Drug Administration's definition, which says drugs are bioequivalent if

- they use the same active ingredient as the original version of this drug and
- that active ingredient is absorbed and available where it's needed in the body at the same rate.

Drugs that are rated as bioequivalent can vary from the original version of the drug in rate and extent of absorption by no more than about 20%, the same variation as may be allowed from one batch of the original version to another. That's based on a decision that, for most drugs, such a difference in the drug's concentration in the blood isn't clinically significant.

Even though the active ingredient is the same, generic versions can vary from the original in several ways, including the way the active ingredient is released in the body, colors, flavors, scoring, and expiration time. We were told these factors may make a patient able to tolerate one version of a drug but not another. Precise concentration in the blood is more important for some drugs than for others, we were told.

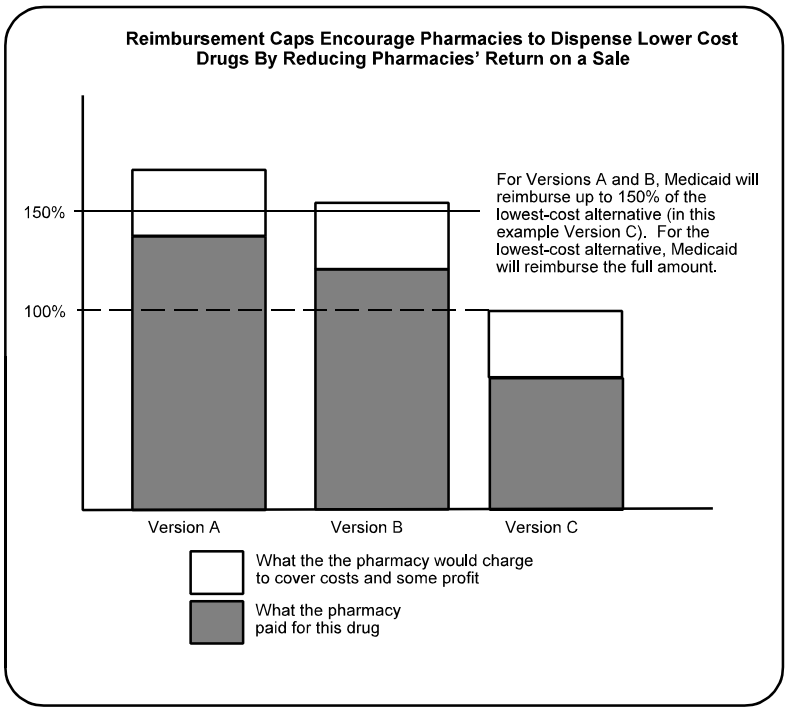
Sometimes the term "generic" is applied to drugs that are "therapeutically equivalent." This term includes drugs that treat the same condition but use different active ingredients.

This cap is helpful in 2 ways:

- it limits what the Medicaid Program will pay for a higher-cost drug when a lower-cost version is available
- it provides an financial incentive to pharmacies to work with physicians to dispense a lower-cost version

Kansas law already allows a pharmacist to substitute a less-costly version of a drug with the prescribers' approval.

In November 1999, the Department implemented a State cap that can apply as soon as there are just 2 versions of a drug. The State cap, like the federal cap, limits what pharmacies receive for specific drugs. Because the State doesn't have to wait for 3 versions to be available, the cap helps the Department save money through the use of generics much earlier than when the Department relied only on the federal cap.



Department officials told us that, as of March 2000, the State cap will be in effect for 82 drugs. This State cap wasn't in place for the year of data we reviewed (fiscal year 1999), but its impact on prescription drug costs reimbursed by the Medicaid Program should show up in fiscal year 2000 and beyond.

Besides the use of reimbursement caps, the use of generic drugs is encouraged in quarterly bulletins sent out by the Drug Utilization Review Board. These bulletins are sent to all pharmacists and physicians who participate in the Medicaid Program. Some bulletin articles announce the availability of new generic drugs and describe their cost-saving potential.

For a Sample of High-Expense or High-Use Drugs, Kansas' Medicaid Program Paid for the Generic Versions of Those Drugs More Than 80% of the Time

To determine the extent to which pharmacists actually dispensed generic versions of drugs to Medicaid clients when those drugs were available from more than one source, we reviewed a sample of those drugs that were in the top 50 in one or both of the following 2 categories in fiscal year 1999:

- drugs the Medicaid Program **spent the most money on**, such as the anti-psychotic medicine clozapine (for which the brand name is Clozaril)
- drugs **prescribed most frequently** for Medicaid clients, such as the antibiotic amoxicillin trihydrate (Amoxil)

In all, 69 drugs fit into one or both of these categories. (A total of 28, such as the stomach acid medicine ranitidine (Zantac), fit into both.) We couldn't identify a name brand for 14 of the 69, including drugs, such as insulin and aspirin, that have been on the market so long there essentially was no name brand drug. Thus, the remainder of our analysis covers 55 drugs, which

accounted for 40% of the amount the Kansas Medicaid Program spent in fiscal year 1999 on drugs available from more than 1 source. Appendix B provides more information about the drugs we reviewed.

For the 55 drugs in our sample, generic versions were dispensed 82% of the time. This percentage is much higher than the 35%-55% that pharmacists told us is the rate for the general public, depending on the insurance plan. In analyzing information from the Medicaid Management Information System and other sources for this sample of drugs, we determined the following:

- The Medicaid Program paid for 793,000 prescriptions for these drugs in fiscal year 1999.
- Of those, 652,000 prescriptions, or 82%, were for the generic version of the drug.
- The federal reimbursement cap was in place during fiscal year 1999 for 28 of these 55 drugs. The State cap will be in effect in fiscal year 2000 for 4 more of the drugs reviewed.

Using generic versions saved the Program $2.2 million in fiscal year 1999. About 46% of that came from just 3 drugs:

ranitidine (Zantac)	$432,000
carbamazepine (Tegretol)	$297,000
propoxyphene napsylate (Darvocet)	$297,000

Our comparisons also showed, however, that the name brand version of a drug **wasn't the most costly option** for 23 of the 55 drugs in our sample and that choosing the least costly version can be complicated. Here are some illustrations:

- We found the name brand manufacturer's product, including the pain relievers Percocet and Lortab, was the **least** expensive for 7 of our 55 sample drugs. However, if all the prescriptions for those 7 drugs had been for the name brand, the Medicaid Program would have saved only about $234,000.

- Rebates from pharmaceutical manufacturers meant that 4 name brand drugs, including Ritalin and Amoxil, were less expensive than their generic equivalents **after those rebates were taken into account**. The State would have saved an additional $700,000 if all the prescriptions for these 4 drugs had been filled with the name brand version. (Other totals we've reported didn't take rebates into account.) The profile on the next page provides additional information about rebates.

If generics had been dispensed for all the prescriptions in our sample, Medicaid might have saved an additional $830,000. More than half of the remaining potential savings are available from one drug alone: clozapine, which is used to treat psychotic disorders, especially schizophrenia. The name brand Clozaril was dispensed for 91% of the prescriptions; if the generic version had been used for all of them, the Medicaid Program might have saved an additional $486,000. During fiscal year 1999, this drug was available from only 2 manufacturers, so no federal price cap applied. A State price cap became effective March 15, 2000.

Even though generic drugs on the whole save money, there will always be reasons why generic drugs aren't dispensed 100% of the time. In our sample, about 18% of the 793,000 prescriptions were filled with the name brand drug instead of the generic equivalent. This varied widely from drug to drug. For example, name brand Lasix, which is used to treat excessive fluid retention, was dispensed less than 1% of the time, but name brand Lanoxin, which is used to treat heart failure, was dispensed 95% of the time.

Information available in the Medicaid Management Information System didn't indicate why generic drugs hadn't been used in these cases. Doctors and pharmacists told us there are good reasons for prescribing and dispensing the name brands of certain drugs. For example, differences in ingredients such as dyes and fillers and in how quickly the body absorbs a drug may mean a patient can tolerate one version but not another. They specifically mentioned thyroid medications, blood thinners, and seizure medications as drugs for which the name brand may be best.

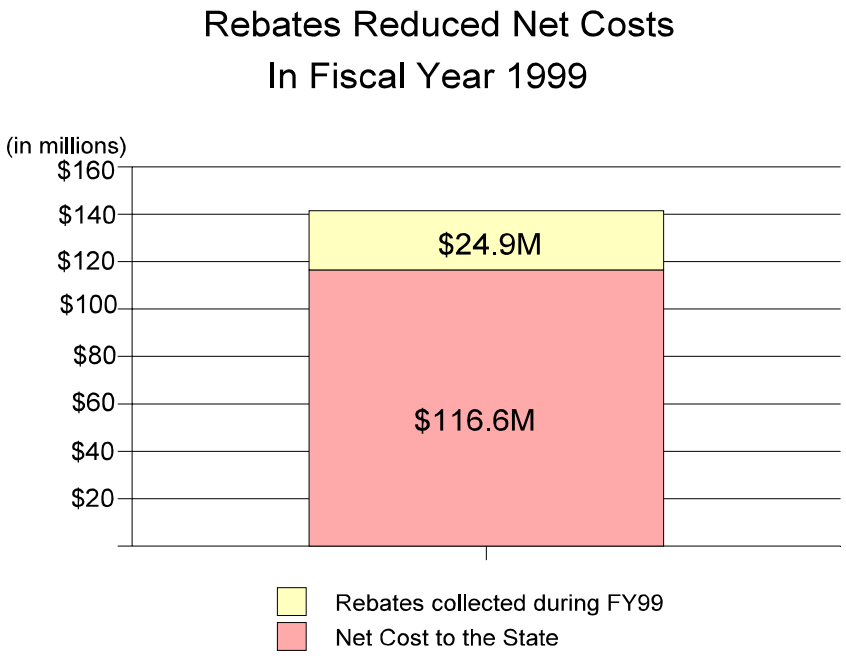
Rebates on Drugs Reduce the State's Net Costs

Rebates from manufacturers meant that the Kansas Medicaid Program recovered nearly $25 million–more than 16%–of its pharmacy expenditures in fiscal year 1999. Rebates go into the State General Fund and, while they're recorded to meet federal requirements, they usually aren't reported as reducing the overall cost of the Medicaid prescription drug program. They do, however, reduce the overall cost to the State.

Pharmaceutical manufacturers have long paid rebates to their best clients. Since 1991, federal Medicaid laws have required manufacturers that want Medicaid to pay for their products to give rebates to the states. The Health Care Financing Administration tells the states each quarter how much each manufacturer will rebate for each drug in each strength or form it's offered.

The Department of Social and Rehabilitation Services and its contractor have increased Kansas' collection of rebates in recent years, to about $14 million in the last 2 quarters of fiscal year 1999. Officials told us they expect rebates to remain at between $6 million and $7 million a quarter. Much of the improvement is due to automation. In earlier years, all figuring of rebate amounts and quarterly billing of manufacturers was done manually–a labor-intensive task for a very small staff because more than 300,000 Medicaid pharmacy claims come in each month and there are more than 500 drug manufacturers. Enhancements to the Medicaid computer system expected this summer should make billing and receiving payments even easier, and the system automatically will add interest to the bill when a manufacturer doesn't pay in a timely manner.

The Department's pharmacy manager has taken additional steps to ensure that Kansas gets all the rebate money it is owed. Among those are face-to-face meetings with manufacturer representatives at government-sponsored gatherings, which the Department has found to be effective in resolving disputes over the amount owed and in improving collections from those manufacturers.



We found higher use of name brands in those categories. We also found high use of name brands for drugs used to treat heart failure and psychotic disorders. Depression, excessive fluid accumulation, hyperactivity, and pain were among the conditions for which we found very low usage of name brands.

The Department Might Be Able To Further Increase the Use of Lower-Cost Versions of Drugs, But Not Without Changes in Laws, Regulations, or Policies

We contacted 10 states reported to have good cost-saving measures in effect in their pharmacy programs: Connecticut, Colorado, Iowa, Louisiana, Mississippi, Nebraska, New Mexico, Pennsylvania, Texas, and Virginia.

Besides relying on reimbursement caps to increase the use of generic drugs, these states are using additional practices that Kansas currently isn't using and could explore, as described in the table below.

Idea	Purpose	Implementing this idea in Kansas would require a change in:		
		law	regulation	policy
Drug Regimen Mandates				
Requiring the client to "fail" with the generic version of a drug before Medicaid agrees to pays for the equivalent name brand (Iowa). (Kansas law currently prohibits this practice in the Medicaid Program.)	The lower-cost drug must be used first, unless medical proof shows the client is not able to use the available generic	✔		
Requiring the use of the generic drug by statute, unless the physician specifies that the name brand should be dispensed (New Mexico). (Kansas law is currently silent on this issue.)	The lower cost drug must be used, unless the physician indicates the name brand is desired.	✔		
Requiring the pharmacy to get authorization from the Department to dispense a name brand drug based on the client's medical condition (Colorado, Pennsylvania). (According to Kansas law, drugs requiring prior authorization must be listed in rules and regulations.)	This would require proof of medical necessity before a client could get a brand name. Adding this "red tape" requires physicians, pharmacists, and clients to work together to provide the information needed for approval.		✔	
Financial Incentives				
Setting a lower co-pay for generic drugs and a higher co-pay for the equivalent name brand (Colorado). (Kansas regulations set co-pay at $2 for both generic and name brand drugs.)	More out-of-pocket expense for a name brand provides clients an incentive to request a generic version when it is available.		✔	
Paying a 50¢ fee to pharmacists to substitute an equivalent generic drug for a name brand drug (Connecticut).	The fee provides further incentive to pharmacists to dispense a generic version whenever it is available.			✔
Educational Initiatives				
Providing a list of substitutable drugs to pharmacies (Virginia).	A list gives pharmacists a resource to consult when considering drug substitution possibilities.			✔

When we asked members of the Kansas Medical Society's Council, a majority of the 16 respondents supported allowing substitution of a less-expensive drug to treat a condition, but they had negative comments about requiring a patient to fail with a less-expensive drug before that patient would be allowed to get the more-expensive treatment.

CONCLUSION

Kansas, like other states, has relied primarily on federal reimbursement caps to encourage the use of generic drugs in the Medicaid Program. The use of generic drugs saved the Medicaid Program an estimated $2.2 million in fiscal year 1999 alone. The Department of Social and Rehabilitation Services' new policy to extend the reimbursement caps to apply to more drugs should provide even greater incentives to use generic drugs. To achieve additional savings, the Department should consider more aggressive initiatives tried by other states, which may require changes to current State law. Nevertheless, there is a limit to how much can be saved by using generics, because about 75% of prescription drug costs are attributable to drugs that don't have generic alternatives. Our recommendations in this area are included with the recommendations following Question 2.

Question II: What Other Measures Does the Department Take To Control Medicaid Drug Costs, And What Additional Steps Should It Explore?

The Department of Social and Rehabilitation Services has implemented many effective cost-control measures in the Medicaid Pharmacy Program, including providing financial incentives to use less costly drugs, limiting the amount of drugs that the State will pay for, and assuring that the State doesn't pay more than it needs to. In addition, the Department takes several steps to prevent fraud and abuse in the Medicaid Program. To help control costs even further, the Department could expand some existing programs and consider implementing initiatives occurring in other states. One initiative in particular, splitting larger-dose tablets when there's little difference in cost between the larger and smaller dose tablets, appears it could save the Program significant money–$700,000 for one drug alone. These and other findings are described in more detail below.

The Department Has Implemented Many Effective Cost-Control Measures In the Medicaid Pharmacy Program

Four primary factors determine the costs in a prescription drug program:

- the type of drug prescribed (for example, newer more expensive vs. older less expensive)
- the amount of drugs prescribed (the size and number of prescriptions paid for)
- the amount paid for a prescription
- the amount of fraud and abuse

In the previous question, we focused on the first factor–the type of drug prescribed–by looking at what the Department does or could do regarding the use of generic drugs. To answer this second question, we examined other steps the Department has taken to control costs in each of the 4 areas above.

Current Department policies and regulations control what types of drugs are prescribed. These policies do such things as encourage the use of the lowest cost drug and require proof of medical necessity before a client can get some expensive drugs.

!	Pricing restrictions	The Department restricts what it will pay for a higher cost drug when generic equivalents are available.
!	Coverage limitations	The Department doesn't pay for most cosmetic drugs, fertility drugs, weight-loss drugs, and many over-the-counter drugs.
!	Prior authorization	Expensive drugs, like growth hormones, and drugs subject to abuse, like amphetamines, require prior authorization from the Department before the drugs are dispensed. To receive authorization, the client must meet specific medical criteria associated with that drug.
!	Drug utilization review	The Department and the Drug Utilization Board use computer edits to review every prescription at the point of sale and provide information electronically to the pharmacy on several items, such as whether the new drug likely will cause an adverse reaction with another drug the client is already taking. In addition, the Board and its subcontractor examine drug use data, targeting high-cost or frequently prescribed drugs and looking at such things as whether a drug is appropriate for the client's diagnosis.

The Department currently limits the amounts of drugs the Medicaid Program will pay for. These limits apply generally to all drugs prescribed to Medicaid clients. Additional limits are placed on drugs the Department has chosen to target.

!	Prescription and refill limits	The Department limits each Medicaid prescription and refill to a 34-day supply to prevent wasting medicine that is dispensed but never used. Also, a client can't get a prescription refilled until 75% of the prescription should have been used. This helps ensure that the medicine is working and a refill is needed.
!	Further limitations on specific drugs	The Department limits the amounts that can be prescribed for specific drugs. For example, prescriptions for Viagra, a highly publicized erectile dysfunction drug, are limited to 4 tabs a month.

The Department currently controls what the State pays for each prescription. These measures can help ensure, among other things, that for each drug the lowest reimbursement option is applied and that other insurance coverage applies first.

!	Reimbursement levels	The Department's Medicaid prescriptions reimbursements are in-line with what other states pay. That goes for payments for drugs and for dispensing fees. This issue is further discussed in the profile on p. The Department further lowers reimbursement amounts for some drugs when pharmacists or local health departments can obtain them at discounted rates.
!	The usual and customary price	The Department pays the lower of the fixed reimbursement rate or the pharmacy's usual and customary price charged to non-Medicaid clients.
!	Co-payment	The Department requires most clients to pay a $2 co-pay for most prescriptions, the maximum allowable under federal and State guidelines. During fiscal year 1999, co-pays reduced the amount Medicaid had to pay to pharmacists by $2.1 million.
!	Other available insurance coverage	The Department has established computer controls to help ensure Medicaid doesn't pay for drugs covered by another insurance policy, including drugs covered by Medicare Part B, which is federally funded without a State match.
!	Handling credits	The Department requires pharmacies to credit the State for all payments for prescriptions that never get picked up.
!	Collecting rebates	Under federal law, pharmaceutical manufacturers must agree to rebate the State for each prescription filled of their drugs if they want their drugs to be available to Medicaid clients. The State has been successful in collecting these rebates from manufacturers who dispute how much of their drugs were sold in Kansas.

The Department currently takes steps to identify and pursue fraud and abuse. The Department does its own reviews and works with the Attorney General's Office to prosecute fraudulent practices.

!	Reviews of billing statements	The Department reviews for problems such as insufficient documentation, misbilling of compound drugs, or billing for the same prescription more than once. It then withholds any money that was incorrectly paid from future payments to those pharmacies. Department records show nearly $300,000 was recovered in fiscal year 1999.
!	Lock-in	When the Department identifies specific clients who are misusing the Medicaid system, those clients may be locked in to one physician, one pharmacy, and sometimes one hospital to monitor their access to health care. The Department reported that these lock-ins avoided costs of about $175,000 in fiscal year 1999.

!	Prosecuting fraud	The Department works closely with the Attorney General's Medicaid Fraud and Abuse Division to pursue cases of fraud perpetrated by pharmacies. These can include billing for drugs not actually dispensed, billing for a more expensive drug than was actually dispensed, or partially filling a prescription while billing for the entire amount.

To Help Control Drug Costs Even Further, The Department Could Expand Some Existing Programs and Consider Implementing Initiatives Other States Are Trying

During this audit, we talked to Medicaid officials from 10 states, interviewed several Kansas pharmacists, and surveyed some Kansas doctors to learn about good cost-savings ideas. Although the Department already had implemented many of the things we heard about, it isn't using a few initiatives other states have tried and found to be successful. In other cases, Kansas had a similar program in place, but to a lesser extent.

Several ideas presented here likely would result in cost savings to the Medicaid Program. However, any new initiative should be further researched to determine whether significant cost savings would be likely in Kansas. The Department has assigned only one person to do this type of research, and she has many other duties besides examining possibilities for cost containment.

The additional cost-saving actions are summarized in the tables on the following pages. These actions are categorized by the factor they impact: type of drug prescribed, amount of drugs allowed, or what the State pays for drugs.

Controlling the Types of Drugs Prescribed	
Expanding coverage of over-the-counter drugs as an alternative to more costly prescription drugs	The Department currently pays for only a few over-the-counter drugs, including acetaminophen, ibuprofen, Zantac, and Pepcid. Officials from Virginia and New Mexico told us they also cover such over-the-counter drugs as antifungal creams and antihistamines. Paying for more over-the-counter drugs could result in some cost savings. An official in Virginia described estimated savings of $460,000 in calender year 1998 and suggested additional savings could be had by aggressively promoting use of over-the-counter drugs.

Expanding the use of prior authorization to limit more drugs to those clients with specific medical needs	Officials from 6 states told us they rely heavily on prior authorization to cut costs. The Department currently has about 50 types of drugs that require prior authorization before they can be dispensed. Putting more high cost drugs on the "prior authorization" list would increase the likelihood that those drugs would be dispensed only when really needed and decrease payment for drugs to those who don't. By law, the Department must use the formal administrative rules and regulations process to place drugs on the prior authorization list. Recently, during the 2000 legislative session, the House Social Services Budget Committee recommended that the Department place additional drugs on the prior authorization list and directed the Department to do so by using a shortened process for adopting temporary rules and regulations.
Requiring the client to fail on a less expensive drug therapy before receiving a more expensive drug therapy	During the 2000 legislative session, the House Social Services Budget Committee proposed introducing a bill that would amend State law to require that the most cost-effective drug therapy be prescribed first, and only upon a showing that the prescribed drug does not prove effective for the patient could a higher-cost drug be prescribed. This proposal is different from generic substitution, because the Department could direct the use of drugs with different active ingredients. For example, this proposal would allow the Department to require clients needing an antibiotic to try and/or fail with a particular low-cost general antibiotic first, before using another more expensive type of antibiotic. Several physicians we surveyed expressed reservations to this approach and told us that a more expensive drug could be cost effective overall, that there was a potential for patients' conditions to worsen, and that there should be "loophole" for those clients who will obviously fail on the less expensive drugs.
Expanding educational efforts of the Drug Utilization Board to focus on cost-effective drug use	Currently the Board's educational activities for physicians regarding what drugs are more cost-effective consists of letters to providers, a quarterly bulletin, and a website. Although the Board tracks providers' reactions to the letters, Board representative told us they haven't evaluated whether their other educational programs are having the impact they intend. Several physicians suggested an increased role of the Board in ensuring that Kansas gets the most benefit from its Medicaid prescription drug dollars, and one physician specifically recommended regular education for physicians on cost-effective alternatives to common drugs and on name brand drugs that avoid expensive complications. Additionally, pharmacists told us that the Board's information could be more helpful than it is.

Reducing the Amount of Drugs Prescribed	
Counsel clients with chronic conditions or diseases on how to better manage those conditions and reduce overall health care costs	Currently, the Department counsels Medicaid clients to a very limited extent. Clients in the managed care program can receive counseling from physicians and pharmacists about diabetes and asthma. Mississippi and Virginia have greatly expanded programs that use Medicaid money to provide client counseling on depression, cardiovascular problems, high cholesterol, and therapy to prevent blood clots, as well as diabetes and asthma. Although these 2 states have taken different approaches to providing counseling, a Virginia cost study on its asthma program showed the counseling actually resulted in increased drug costs. However, the program reduced overall medical expenditures by $3-$4 for every additional $1 spent on counseling patients. Pharmacists we spoke to were in favor of this approach, but physicians we surveyed were worried that pharmacists could be inappropriately acting as physicians.
Using a "starter dose" to ensure the medicine is working without adverse effects	Pharmacists we talked to suggested the Department could limit new prescriptions to clients to a supply for 7-10 days. If the medicine was working, clients could return to the pharmacy for the rest of the month's supply. If the medicine wasn't right, the remainder of the prescription wouldn't be wasted.

Controlling What the State Pays for Medicaid Prescriptions	
Splitting larger dose tablets in two when there's little cost difference between the larger and smaller dose	A Nebraska Medicaid official told us about a new initiative to split tablets of the antidepressant Zoloft. Those officials estimated they could save $300,000 a year if all prescriptions for 50-mg doses were filled with split 100-mg tablets, even after paying pharmacies 15¢ a tablet to split them. Private insurers use this cost-saving idea, they said. Kansas' Medicaid Program paid for about 788,000 50-mg tablets of Zoloft in fiscal year 1999. It paid $1.92 for each 50-mg Zoloft tablet, but only $1.96 for each 100-mg tablet dispensed. If all the 50-mg doses had been split from 100-mg tablets, Kansas might have saved more than $675,000 of the $1.5 million it spent on 50-mg Zoloft tablets, even after paying pharmacists extra to split the tablets. Nebraska is considering extending this policy to other drugs that have a high cost per dose, such as Celexa, an anti-depressant, and Viagra. It appears Kansas could save money on these and other drugs, as well, by paying pharmacists to split larger doses into smaller ones.

Reducing the level of reimbursement to lower the State's costs	Officials from 4 states told us they'd reduced their reimbursement levels within the past 3 years. Also, a September 1999 study by Myers & Stauffer requested by the Department recommended 2 changes to the reimbursement formula: ! using a single dispensing fee for all pharmacies. This change would increase costs by approximately $1 million. ! reducing the amount paid for the drug product. This change would decrease costs by $1 million for each percentage dropped. During the 2000 Legislative Session, the House Social Services Budget Committee also endorsed a reduction in the amount paid for the drug product from 90% of the product price to 87%. The Committee accordingly recommended a $3 million reduction in the Medicaid pharmacy budget.

The Drug Utilization Board and the Attorney General's Office Help Control Costs in the Medicaid Program

Medicaid costs are impacted by physicians prescribing inappropriate drugs and pharmacists committing Medicaid fraud. The Drug Utilization Board and the Attorney General's Office help the Department to track down these instances.

The Drug Utilization Board examines drug use data, looking for evidence that a physician prescribed an inappropriate drug to a Medicaid client. When questionable prescriptions are identified, the Board sends out educational letters to physicians and pharmacists suggesting a lower cost alternative prescription. The Board then tracks the drugs prescribed for the client to determine whether there is a change in drug therapy. As a result of these letters for one month in 1999, the Board estimated, Medicaid saved $160,000.

The Attorney General's Office identifies possible Medicaid fraud from referrals from Department or Board of Pharmacy, federal fraud alerts, and public complaints. Pharmacists who knowingly, and with intent to defraud, submitted false claims to the Medicaid Program can be required to pay back the money they stole. In the past year and a half, the Attorney General recovered $3,500 from a local pharmacist who was billing for drugs that weren't actually dispensed. Additionally, participation in a national investigation dealing with partially filled prescriptions and promoting drugs for unapproved uses recovered $104,000 for Kansas.

Medicaid Reimbursement in Kansas Compares Favorably to Reimbursement In Other States

Across the country, Medicaid prescription drug reimbursement is made up of 2 components:

! a fee paid to a pharmacy for dispensing the drug to Medicaid clients

! reimbursement for the drug itself

Kansas' dispensing fee is in line with what other states pay. The fee is individually determined for each pharmacy that participates in the Medicaid program. The fees range from $2.81 to $6.71, with an average of $4.94. According to 1998 data collected by the National Pharmaceutical Council, dispensing fees across the country range from a low of $2.00 in Montana to a high of $14.72 in Illinois.

Similarly, Kansas' level of reimbursement for prescription drugs is much like that of other states. Kansas' reimbursement is set according to a nationally determined product price less 10%. In other words, Kansas reimburses 90% of the national drug price. According to the National Pharmaceutical Council, 45 states use the same national drug price and most states reduce the drug price by some percentage. Idaho reimburses 100% of the national drug price, while Michigan reimburses around 85% of the national drug price.

CONCLUSION

The Department is taking many steps to cut costs in the Medicaid drug program. These steps are important because the use of drugs, as well as the cost of new drugs, will only continue to increase costs to Medicaid. The Department could expand its efforts in several areas; some may require a change in law while others would require simply a change in policy. Some investigation into the cost-effectiveness of additional initiatives is merited, but at least one initiative regarding the splitting of larger tablets of certain drugs appears it would save a significant amount of money. Currently, the Department has one staff member working exclusively with the Medicaid drug program, and her other duties limit the amount of time she has to investigate and implement new ideas.

As Department officials consider initiatives, they should be alert to changes that would decrease drug costs but increase general health care costs. Restricting or hindering access to an expensive drug might make someone sicker and require hospitalization or other intensive health care services.

RECOMMENDATIONS

1. The trend toward increasing prescription drug costs merits putting resources toward avoiding excess costs whenever possible. The Department of Social and Rehabilitation Services should set priorities and examine the cost-effectiveness of additional cost-cutting ideas regarding prescription drugs in the Medicaid Program. To do so, it likely may need to add research capability to the pharmacy program. We identified these ideas that merit additional research:
   - ! expanding coverage of over-the-counter drugs
   - ! expanding the use of prior authorization
   - ! requiring a client to fail on a less expensive drug therapy before receiving a more expensive version
   - ! counseling clients with chronic conditions or diseases to better manage those conditions
   - ! using a “starter dose”

- paying pharmacists to split larger-dose tablets when there's little cost difference between the larger- and smaller-dose tablets
- reducing the level of reimbursement for drugs

2. The Department and the Drug Utilization Review Board should evaluate the effectiveness of the Board's outreach to Medicaid providers and determine whether educational activities should be altered or enhanced.

APPENDIX A

Scope Statement

This appendix contains the scope statement approved by the Legislative Post Audit Committee for this audit on May 25, 1999. The audit topic was suggested to the Committee by staff of the Legislative Division of Post Audit.

SCOPE STATEMENT

Reviewing the Medicaid Program's Use of Generic Drugs

The Medicaid Program provides medical benefits for qualified individuals. These benefits include prescription drugs. During fiscal year 1998, the program's costs for prescription drugs was about $117 million. (This figure doesn't include rebates from pharmaceutical companies of about $25 million. However, because these rebates weren't credited back to the Medicaid Program's drug budget, the Program's drug costs don't seem to be impacted by the rebates. Further, this may be contrary to federal requirements.)

Legislative concerns have been raised about the extent to which the program makes use of generic equivalents for name brand drugs, and what the program does to encourage the use of generic drugs. Generally, the generic equivalents are less costly, and the more such drugs are used, the less the Program's costs for prescription drugs. According to Program officials, pharmacists are allowed to substitute generic versions of prescribed drugs, and the federal Health Care Finance Administration sets maximum prices that can be paid for drugs under the Medicaid Program. Those maximum prices are set at 150% of the lowest cost available variety of a particular drug, including generic versions. That means that as the less costly generic versions of drugs become available, the maximum price that can be paid under the Program goes down, and the more likely that generic versions will be used.

A performance audit to address these concerns would answer the following questions:

1. **How often is the Medicaid Program paying for name brand drugs when generic equivalents are available, and what is the additional cost of using the name brands?** To answer this question, we'd interview program officials and others as appropriate to identify any generic equivalents available for the most commonly used name brand drugs under the Medicaid Program. We'd then review payment records for the most recent fiscal period to determine how frequently the name brand drugs are used instead of the generic equivalents, and the applicable reimbursement costs. Using this usage and cost information, we'd determine the additional cost of using the name brands.

2. **How do reimbursement rates for drugs in the Kansas Medicaid Program compare with reimbursement rates in other states?** To answer this question, we'd interview Kansas officials and review reimbursement rate schedules to identify Kansas reimbursement rates. We'd survey a sample of

other state program officials to identify those states' reimbursement rates. We'd analyze the results to see how Kansas' rates compare to those of other states. We'd also identify the impact, if any, of federal program regulations and guidelines. In addition, we'd look into whether prescription-by-mail service has the same reimbursement rates.

3. **What incentives could be used to encourage the use of generic drugs?** To answer this question, we'd interview program officials in Kansas, program officials in the sample of other states contacted for the question above, and federal program officials. We'd also contract a sample of physicians, pharmacists, and representatives of pharmaceutical companies. Finally, we'd interview a sample of doctors, pharmacists, and representatives of pharmaceutical companies to identify any relevant issues regarding the use of generic equivalents rather than name brand drugs.

Estimated time to complete: 8-10 weeks

APPENDIX B

Drugs Available from More Than One Source That Were Included in Our Sample

This appendix lists the drugs we included in the sample we used to determine how often the Medicaid Program paid for name brand drugs when generic versions were available. (For purposes of this audit, we defined a drug as a unique combination of generic ingredient and strength.) The appendix also lists the name brand and includes information about what this drug is used for, the number of manufacturers (or labelers), whether the brand name version was the most expensive of the versions in our sample, the number of prescriptions for this drug, and how much Medicaid spent for this drug in fiscal year 1999.

Appendix B

Drugs Available from More Than One Source That Were Included in Our Sample

Ingredient Name	Strength	Name brand	Drug is frequently used for this type of condition	# of manu-facturers	Did the name brand cost the most?	Total prescriptions for this drug	Prescriptions for the name brand version	How much Medicaid spent in FY99 (1)
ACETAMINOPHEN	325MG	Tylenol	pain	29	Yes	12,863	248	$23,760
ACETAMINOPHEN	500MG	Tylenol	pain	29	No	15,631	1,091	$42,695
ALBUTEROL	90MCG	Ventolin	asthma	15	No	38,494	317	$298,968
ALBUTEROL SULFATE	0.83MG/ML	Ventolin	asthma	13	Yes	13,088	2	$354,842
ALBUTEROL SULFATE	5MG/ML	Ventolin	asthma	15	No	19,816	152	$275,122
AMIODARONE HCL	200MG	Cordarone	heart arrhythmia	6	Yes	2,001	986	$219,100
AMITRIPTYLINE HCL	25MG	Elavil	depression	16	Yes	10,276	13	$13,114
AMOXICILLIN TRIHYDRATE	500MG	Amoxil	infection	17	No	17,852	1,263	$102,039
AMOXICILLIN TRIHYDRATE	250MG/5ML	Amoxil	infection	18	No	18,952	7,368	$55,249
AMOXICILLIN TRIHYDRATE	125MG/5ML	Amoxil	infection	18	No	10,476	4,361	$19,734
BENZTROPINE MESYLATE	1MG	Cogentin	psychotic disorders	18	No	10,338	20	$8,992
CARBAMAZEPINE	200MG	Tegretol	seizures	15	Yes	16,567	1,159	$254,144
CEPHALEXIN MH	500MG	Keflex	infection	19	No, least	17,649	10	$93,456
CLONAZEPAM	1MG	Klonopin	anxiety	8	No	9,844	474	$398,225
CLONAZEPAM	0.5MG	Klonopin	anxiety	8	No, least	15,381	560	$368,370
CLONIDINE HCL	0.1MG	Catapres	hypertension	9	Yes	13,460	6	$17,196
CLOZAPINE	100MG	Clozaril	psychotic disorders	2	Yes	19,618	17,856	$2,718,038
CLOZAPINE	25MG	Clozaril	psychotic disorders	2	Yes	6,702	6,111	$257,027
CODEINE PHOSPHATE/APAP	30-300MG	Tylenol w/ codeine	pain	16	No	19,909	69	$39,656
CYCLOBENZAPRINE HCL	10MG	Flexeril	muscle pain	19	No	11448	17	$28,784
DIGOXIN	250MCG	Lanoxin	heart failure	8	No	15,111	14,295	$58,847
DIGOXIN	125MCG	Lanoxin	heart failure	8	No	32,114	30,342	$119,138
FUROSEMIDE	20MG	Lasix	excessive fluid accumulation	17	Yes	27,351	151	$18,286
FUROSEMIDE	40MG	Lasix	excessive fluid accumulation	16	Yes	52,410	277	$46,727
FUROSEMIDE	80MG	Lasix	excessive fluid accumulation	14	No	12,575	77	$35,464
GLYBURIDE	5MG	Micronase	diabetes	10	Yes	10,137	189	$301,720
HALOPERIDOL DECANOATE	100MG/ML	Haldol	psychotic disorders	4	Yes	677	504	$151,683

Ingredient Name	Strength	Name brand	Drug is frequently used for this type of condition	# of manu-facturers	Did the name brand cost the most?	Total prescriptions for this drug	Prescriptions for the name brand version	How much Medicaid spent in FY99 (1)	
HYDROCHLOROTHIAZIDE	25MG	Hydrodiuril	fluid accumulation, high blood pressure	17	No, least	9,603	1	-$3,884	(2)
HYDROCODONE BITARTRATE/APAP	5-500MG	Lortab	pain	24	No, least	28,675	39	$14,942	
HYDROCODONE BITARTRATE/APAP	7.5-500MG	Lortab	pain	13	No	15,626	191	$106,747	
IBUPROFEN	800MG	Motrin	inflammation, pain	19	No	14,726	26	$26,386	
IPRATROPIUM BROMIDE	0.2MG/ML	Atrovent	chronic bronchitis, emphysema	4	Yes	9,980	167	$608,645	
LEVOTHYROXINE SODIUM	100MCG	Synthroid	thyroid malfunction	15	Yes	18,245	9,572	$96,622	
LEVOTHYROXINE SODIUM	50MCG	Synthroid	thyroid malfunction	15	Yes	13,217	9,013	$71,956	
METHYLPHENIDATE HCL	5MG	Ritalin	hyperactivity	15	No	9,548	328	$210,717	
METHYLPHENIDATE HCL	10MG	Ritalin	hyperactivity	16	No	11,456	358	$352,622	
METHYLPHENIDATE HCL	20MG	Ritalin	hyperactivity	13	No	4,412	391	$180,015	
NICOTINE	21MG/24HR	Habitrol	smoking addiction	4	Yes	2,665	323	$175,875	
NITROGLYCERIN	0.4MG/HR	Nitro-Dur	angina	5	No	4,556	1,500	$202,814	
NITROGLYCERIN	0.2MG/HR	Nitro-Dur	angina	5	No	5,903	1,927	$226,963	
OXYBUTYNIN CHLORIDE	5MG	Ditropan	overactive bladder	15	No, least	12,094	9	$111,844	
OXYCODONE HCL/ACETAMINOPHEN	5-325MG	Percocet	pain	11	No, least	9,009	6	$19,120	
PENTOXIFYLLINE	400MG	Trental	poor circulation	9	Yes	7,047	686	$289,230	
PHENYTOIN	125MG/5ML	Dilantin	seizures	2	Yes	4,681	3,222	$140,265	
PHENYTOIN SODIUM EXTENDED	100MG	Dilantin	seizures	2	Yes	8,771	8,342	$190,054	
POTASSIUM CHLORIDE	10MEQ	K-Tab	low potassium	12	Yes	14,925	508	$123,250	
PREDNISONE	10MG	Deltasone	inflammation	14	No	9,499	1,567	$7,812	
PROPOXYPHENE NAPSYLATE/APAP	100-650MG	Darvocet	pain	16	No	47,029	135	$184,941	
RANITIDINE HCL	150MG	Zantac	stomach acid	15	Yes	26,347	710	$967,077	
SUCRALFATE	1G	Carafate	ulcers	7	Yes	4,494	211	$234,420	
SULFAMETHOXAZOLE/TRIMETHOPRIM	800-160MG	Bactrim	infection	23	No	15,161	27	$14,702	
TAMOXIFEN CITRATE	10MG	Nolvadex	breast cancer	2	Yes	2,892	422	$275,068	
TRAZODONE HCL	50MG	Desyrel	depression	16	No, least	15,148	4	$26,696	
WARFARIN SODIUM	5MG	Coumadin	prevents blood clots	3	Yes	9,813	7,896	$176,513	
WARFARIN SODIUM	2MG	Coumadin	prevents blood clots	3	Yes	6,464	5,131	$119,194	

(1) The amount Medicaid spent for the drug equals the total amount paid the pharmacies minus the dispensing fee. It does not include co-payments, which Medicaid clients paid.
(2) For hydrochlorothiazide, the amount paid in dispensing fees exceeded the amount paid for the drug.

APPENDIX C

Agency Response

On March 8, 2000, we provided copies of the draft audit report to the Department of Social and Rehabilitation Services. The Department's response is included as this Appendix.

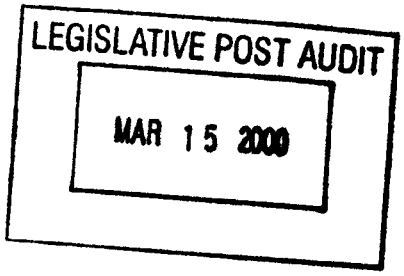
BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

JANET SCHALANSKY, SECRETARY

March 14, 2000



Ms. Barbara J. Hinton
Legislative Post Auditor
Mercantile Bank Tower
800 SW Jackson St., Suite 1200
Topeka, KS 66612-2212

Dear Ms. Hinton:

We have reviewed the draft copy of the performance audit "Reviewing the Medicaid Program's Use of Generic Drugs." In general, we found the audit to be a thorough review of the Medicaid pharmacy program. We appreciate the balance of the report and the inclusion of the many cost control measures the agency has implemented as well as the reference to statutes and regulations that structure the program.

The performance audit was a valuable review of the pharmacy program and the report highlights the challenges we face in controlling prescription drug expenditures. We appreciate the recommendations received from the Division of Legislative Post Audit. As mentioned in the report, many of the recommendations require a change in statute or regulation. The recommendations that do not require a change in statute or regulation include: expanding the coverage of over-the-counter (OTC) medications, counseling clients with chronic diseases (disease management), paying for a "starter dose," requiring pharmacists to split tablets and reducing pharmacists reimbursement.

Medicaid does cover OTC medications if they have a prescription strength equivalent, are rebated and are less expensive than the prescription equivalent. There are a few OTC antifungal medications recently available that could represent some minor savings to the State and thus warrant further investigation.

The recommendation to counsel clients with chronic diseases is currently performed by our managed care providers in the HealthWave and PrimeCare programs. We are investigating the successes of these programs in improving the health of our beneficiaries, potential long term savings and application to the Medicaid fee-for-service population. It is important to reiterate that this type of program may increase prescription drug cost yet lower total health care costs.

Several of the recommendations will require additional research to determine actual cost-savings and feasibility of implementation. Coverage of a "starter dose" for new prescriptions of maintenance medications requires research to verify that the State would not be paying more in dispensing fees than any savings from drug wastage that is prevented.

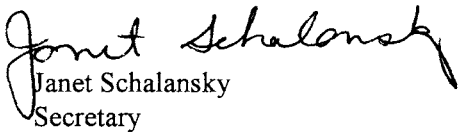
In regard to the recommendation to require pharmacy providers to split tablets prior to dispensing, there are several safety concerns that must be investigated. Although there may be savings from cutting tablets in half, this should not be at the expense of patient safety. A recent publication from the National Association of Boards of Pharmacy addresses the same concern.

Additionally, a reduction in pharmacist reimbursement must be weighed against placing more requirements on the pharmacy provider, as many of the above recommendations do. Another important issue is the potential for reduced consumer access to medications if pharmacy providers refuse a lower reimbursement. Further research into the above recommendations will assist in determining actual savings that may exist.

Lastly, the recommendations to utilize "step therapy," the use of effective, less costly medications before more expensive medications are used, requiring the use of generic drugs and expanding the use of prior authorization require a change in statute or regulation. The agency supports any change that gives us the flexibility needed to provide quality health care services while managing the costs of the program.

Thank you for the opportunity to comment on the draft audit report.

Sincerely,



Janet Schalansky
Secretary
Kansas Department of Social and Rehabilitation Services